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Field notes in the clinic: on medicine, anthropology and pedagogy in South Africa

Michelle Pentecost

The X-ray meeting takes place in the busy emergency department of an overcrowded district hospital. As is the case for many of South Africa's smaller public hospitals, there is no in-house radiologist and most X-rays are interpreted by senior doctors. Once a week, a pulmonologist makes the trip from the tertiary hospital in central Cape Town to review X-rays that have proved challenging to interpret, and to teach colleagues and students. Only a few films are presented: there is only an hour to utilise the specialist's expertise.

Medical officers, interns and students crowd around the wall-mounted computer screen to review the week's X-rays. The first film has everyone puzzled. What to make of the white beads that are scattered across the chest radiograph? Matter out of place. The pulmonologist starts: 'Buckshot.' Buckshot. His explanation is brief: the small pellets long used by police for containing protesters in South Africa. For a brief moment, biomedicine's borders are perforated; here is literal evidence of history inscribed in the skin. And then just as quickly this interesting factoid is passed over, and the pulmonologist starts describing the lung parenchyma and the likelihood of tuberculosis infection. The students are schooled in approaching an X-ray systematically: check the name and the date; comment on the film quality - position, inspiration, exposure, rotation. The session ends with questions for the specialist: the students are eager to learn the differential diagnosis for a widened mediastinum, or why there might be more space between the lungs. No one has any further questions about the white dots that pepper the screen.

A field note taken in the clinic; a note that technically should not have been recorded. While briefly noteworthy as a radiological oddity, the buckshot (or more likely birdshot, small lead pellets) is not clinically significant in the face of the patient's primary diagnosis: pulmonary tuberculosis. *Not clinically significant.* And yet captured in this image is the limit of biomedicine. The X-ray confounds the medical gaze: there is no way to read it without reaching for history. The field note that could be written here - the life history and events reflected in those tiny radio-opaque stars - is smoothly passed over to return swiftly to available systems and taxonomies: *lung fields, hilum, heart, mediastinum.*

This commentary is about medicine, anthropology and pedagogy: about the ways of knowing that different disciplinary orientations permit, and the productive tensions and opportunities that subversion of categories might afford. As a physician-anthropologist, I am interested in how we come to foreground certain objects and background others in our view. As medical students we are taught to see past the white speckles that obscure the film to read the reticular pattern of lung fields that might proffer a diagnosis. As an anthropologist, one is trained to continually broaden the field of vision: to capture details that might slowly make visible what is not immediately apparent.

One way to juxtapose these ways of knowing is in the differential registers of the 'clinical note' and the 'field note'. 'Clinical notes' and 'field notes' stand as powerful totems for their respective disciplines. Training in medicine, the art of recording a

history and examination in a standardised fashion is the hallmark of clinical communication: can the student successfully filter surplus information to be left with a neat typology? '59 year old female, #Hypertension, #HIV, #TB.' Well before Twitter popularised hash tag use, medical notes in South Africa have used the hash tag as a form of shorthand for summarising a patient profile. '60 year old male, #Hyperlipidaemia, #Diabetes Mellitus II, #Unstable Angina' captures the patient's medical background and acute problem. Well-written notes would be complemented by a social history, but I have quite often encountered the problematic shorthand of '#Social' as an index of drug abuse, family difficulties, unemployment or homelessness. The clinical note is a codified representation of a patient's pathology, and a useful way for clinicians to communicate with one another. Yet when social histories are overlooked, or summarised with a 'social' hash tag, vital information about the patient is lost. As philosopher and clinician Berna Gerber writes, 'doctors cannot directly apply their general scientific knowledge of biological laws and facts, such as pathophysiology, to identify and treat disease in individual patients. This is because biological laws are imprecise and abstract and individual patients are unrelentingly unique'¹. For capturing the 'unrelentingly unique', field notes are the paper talismans of the anthropologist. Always to be recorded the same day, never to be put off for fear of forgetting some crucial details, the field note encompasses memory, observation, curiosity, and openness.

So here is a provocation: what might be the pedagogical opportunities of encouraging health sciences students to take 'field notes' in the clinic? While the notion of 'clinically-applied anthropology' has contributed to formalising the discipline of 'social medicine' in other contexts, anthropology has only more recently come into conversation with medicine in South Africa as part of an emerging focus on the health humanities. From a pedagogical perspective, an anthropological orientation in the clinic has much to offer. Elsewhere in this special issue, my co-authors and I pose four critical orientations for humanising health sciences education in South Africa: questioning knowledge hierarchies; challenging the image of the health professional; cultivating a social ethic; and privileging relatedness. These critical orientations are all anthropological in nature. Thinking ethnographically, we could summarise this approach as: *note-taking* accompanied by *taking note*. As anthropologist Michael Osterweil has argued, engagement is not 'something we do "out there" ', but is rather as a form of critical self-reflection that recognises and questions the common ideologies and epistemologies in which our practice is situated². Taking note is to reflect critically on the frame of our gaze, what we include or exclude, how we diagnose or analyse, how we engage and respond, and how this relates to questions of power, voice, and positionality. It is in this mode of careful attention that one may *notice* - in the Latin origin *to make known* - to see and know those with whom we engage.

To take field notes in the clinic is then a method of resisting abstraction, of continually foregrounding that which so easily falls into relief. I would like to argue that this is not simply about 'bearing witness' to patients' suffering as an outcome of structural violence in the tradition of liberation theology³. Training health sciences professionals to observe in the tradition of anthropological inquiry does more than improve their understanding of their patients' worlds; it also gives them a language for describing the conditions in which they work. Talbot and Dean have recently described this as recognising that clinicians increasingly suffer 'moral injuries'

working in contemporary health care.⁴ The term 'moral injury', they explain, was first used in the context of war veterans⁵; for clinicians, they describe this as "being unable to provide high-quality care and healing in the context of health care"⁴. Moral injury has all the hallmarks of burnout, but reflects more than over-work: it is the outcome of repeatedly confronting the disjunctures between what should be done and what can be done for patients in the context of broken health systems. In the South African context moral injury is implicit in the need to side-line historical, social and political backgrounds of health and illness - to see through the buckshot spray on the film. It is the capturing of factors that might contribute to a patient's condition with the hash tag '#Social' in a clinical note because this is the accepted shorthand, when this in itself is a form of epistemic violence that contributes to the injury of patient and practitioner alike.

Instead, might we encourage what physician-anthropologist Carolyn Sufrin has called 'concurrent clinical practice and anthropological inquiry'⁶? Might we encourage students to maintain openness and curiosity - to write clinical notes but also to take note? To take note is to challenge knowledge hierarchies that relegate some information to a catch-all 'social' hash tag. It is to think of oneself as a healer rather than a clinician-scientist. It is to demand cognisance of the historical and political contexts of health and illness: to uphold a social ethic that foregrounds social justice. To take note is to privilege relatedness, or the quality of our relationships with patients and with each other as practitioners. To embed these orientations in clinical work and teaching is to offer students a language for that which does not fit into neat biomedical taxonomies. In practice, this commentary is directed at the clinical teachers among us. It is a reminder that students 'take note': they learn from their role models. In South Africa, it is time for a renewed commitment to teach what it is to extend humanity to our patients, and to ourselves.

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